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ABSTRACT

At the request of Senator Daniel Patrick Moynihan, the General Accounting Office (GAO) examined the causes of interstate variations in Medicaid spending and the growth in overall spending. Using published and unpublished information, the GAO identified trends and wide variations among states in Medicaid spending and compared eligibility criteria used, the scope of services offered, and reimbursement to providers. Medicaid spending in New York was compared to national averages and studies analyzing the underlying causes of variations were reviewed. The results of the GAO investigation revealed that growth in spending for Medicaid during fiscal years 1965-1980 was primarily caused by increasing use and an expanding Medicaid population. Growth in spending in fiscal years 1981-1983 was attributable primarily to inflation. The distribution of payments within the Medicaid program has shifted from acute care for the disabled and Aid to Families With Dependent Children to long-term care for the elderly and chronically ill. The Medicaid literature suggests that similar people in similar circumstances but in different states are treated unequally in terms of both Medicaid eligibility and generosity of benefits. Interstate variations appear to be caused by variations in the availability of financial resources across states and by the social and political variables which influence the ways states choose to structure their Medicaid programs. (Sixteen data tables are included.) (NB)

United States General Accounting Office

GAO

Briefing Report to the Honorable Daniel Patrick Moynihan, United States Senate

May 1987

MEDICAID

Interstate Variations in Benefits and Expenditures

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226691

May 4, 1987

The Honorable Daniel Patrick Moynihan
United States Senate

Dear Senator Moynihan:

This briefing report responds to your August 4, 1986, request for information on the causes of interstate variations in Medicaid spending and the growth in overall spending. Using published and unpublished information, we identified trends and wide variations among states in Medicaid spending and compared (1) eligibility criteria used, (2) the scope of services offered, and (3) reimbursement to providers; furthermore, we compared Medicaid spending in New York with national averages. Finally, we reviewed and summarized studies analyzing the underlying causes of the variations identified.

TRENDS IN MEDICAID SPENDING

Growth in spending for Medicaid during fiscal years 1965-80 was primarily caused by increasing utilization and an expanding Medicaid population; growth in spending during fiscal years 1981-83 was attributable primarily to inflation. Both utilization and the Medicaid population fell during this 3-year period. Moreover, the distribution of payments within the Medicaid program has shifted over time from acute care for the disabled and Aid to Families With Dependent Children (AFDC) recipients to long-term care for the elderly and chronically ill. In fiscal year 1984, Medicaid payments totaled approximately $34.5 billion, including about $17.0 billion for long-term home care. Our analysis of the trends in Medicaid spending begins on page 10.

INTERSTATE VARIATIONS IN MEDICAID SPENDING

The Medicaid literature documents pervasive "horizontal inequity"--similar people in similar circumstances but in different states are treated unequally in terms of both Medicaid eligibility and generosity of benefits. The latitude given states to define their Medicaid programs has resulted in a set of programs that appear more different than alike. In nine states, there were fewer than 25 Medicaid recipients for every 100 residents below the federal poverty level, but Hawaii

had 104 Medicaid recipients for every 100 residents in poverty. Significant measures of Medicaid spending--per recipient, per capita, and per person in poverty--indicate large disparities. In fiscal year 1985, annual expenditures per Medicaid recipient averaged $1,721, ranging from $821 in West Virginia to $3,384 in New York.

It is mandatory that states, at a minimum, extend Medicaid coverage to all categorically needy people receiving cash payments from the AFDC program and most people receiving them from the Supplemental Security Income (SSI) program. It is optional for states to extend Medicaid coverage to other groups of the categorically needy, such as those eligible for but not receiving cash assistance. In addition, states can extend Medicaid coverage to the medically needy--people who meet all criteria for categorically needy assistance with the exception of income and who have relatively large medical bills.

Variations in program structure affect per recipient expenditures measured by eligibility category (for example, AFDC, SSI, or medically needy) and by type of service provided (for example, hospitalization or prescription drugs). In general, certain program characteristics tend to increase expenditures per Medicaid recipient. These are (1) a high AFDC payment to meet a minimum standard of living, (2) a liberal definition of medically needy, (3) a relatively high number of optional services (such as prescription drugs), and (4) relatively generous payments to providers of medical services.

A 1984 study conducted for the Department of Health and Human Services by the Center for Health Economics Research grouped state Medicaid programs based on three factors--eligibility (breadth of coverage), number of benefits provided (depth of coverage), and reimbursement to providers. Although federal statutes mandate eligibility for certain of the poor, wide discretion remains to the states in defining and certifying eligibles--especially the medically needy. Ultimately, breadth of coverage depends on the liberalness of Medicaid eligibility standards for (1) definitions of mandatory and optional groups to be covered and (2) income and asset limits for the AFDC and SSI programs.

In 1986, six states (Hawaii, Minnesota, New York, Pennsylvania, Rhode Island, and Wisconsin) provided Medicaid coverage to five major optional groups (see p. 24), whereas Indiana and Missouri covered none of the groups; 13 other states covered only one optional group (see p. 24). Concerning income limits to qualify for Medicaid under AFDC rules, a family of three could have maximum annual income ranging from $1,416 in Alabama to $8,880 in Alaska. Similarly, to qualify for Medicaid under SSI

rules, an individual could have maximum income ranging from $4,032 in 22 states to $7,260 in Alaska. (See pp. 18-25.)

Concerning depth of coverage, we found wide variations both in limits on the number of services allowed for Medicaid recipients and in the payments per enrollee. For example, 10 states had placed limits on the number of inpatient hospital days of care allowed, ranging from 12 days in Alabama to 60 days in West Virginia. Concerning payments per recipient, the widest variations were for (1) optional groups, where payments per recipient ranged from $1,580 in West Virginia to $9,178 in Nevada and (2) SSI cash recipients, where payments per recipient ranged from $705 in Idaho to $8,370 in Illinois. (See pp. 26-29.)

Concerning reimbursement to providers, the methods used by most states indicated an attempt to pay providers less than going market rates. However, wide variations existed in average payments both for inpatient care and physician services. For example, 1985 hospital payments ranged from an average of $160 per day in Nebraska to $533 per day in the District of Columbia. Similarly, payments for a brief office examination ranged from $6.00 in New Hampshire to $28.41 in Alaska. (See pp. 30-35.)

CAUSES OF INTERSTATE VARIATIONS

Health policy researchers attribute interstate variations to two underlying causes. First, the availability of financial resources varies widely across the states. Although the Congress provided economic incentives in the matching formula to encourage comparability in Medicaid programs, the formula does not fully reduce tax burden disparities among the states.

In general, poor states must still impose relatively higher tax rates to provide programs comparable with wealthier states. To avoid higher taxes, these states tend to control expenditures by limiting eligibility, benefits, or both. Second, in the absence of more restrictive mandatory federal regulations, many social and political variables influence the ways states choose to structure their Medicaid programs. Even if tax burdens were equalized, these social and political variables would cause states to set differing eligibility standards, offer different benefits, and reimburse providers differently.

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As requested by your office, we did not obtain written agency comments on this briefing report.

Unless you publicly announce its contents earlier, we plan no further distribution of this briefing report until 30 days from its issue date. At that time, we will make copies available to other interested parties. If you have any questions about the contents of this document, please call me on 275-6195.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

Contents

ABBREVIATIONS

AFDC	Aid to Families With Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ICF	intermediate care facility
ICF-MR	intermediate care facility for the mentally retarded
SNF	skilled nursing facility
SSI	Supplemental Security Income

MEDICAID: INTERSTATE

VARIATIONS IN BENEFITS AND EXPENDITURES

INTRODUCTION

The Medicaid program was enacted to provide the poor with access to mainstream health care. Authorized under title XIX of the Social Security Act, Medicaid was part of the Social Security Amendments of 1965 (Public Law 89-97). The program is jointly financed with state and federal funds; the latter are determined by a statutory formula that provides a higher federal share to states with lower per capita income. The law establishes a minimum federal payment of 50 percent and a maximum of 83 percent. Currently, the highest rate is 78.42 percent.

Within broad federal guidelines, each state designs and administers its own Medicaid program. Consequently, significant interstate variations exist along important program dimensions--eligibility requirements (breadth of coverage), benefits provided (depth of coverage), and provider reimbursement policies.

With regard to breadth of coverage, Medicaid' eligibility provisions are among the most complex of all assistance programs. At a minimum, it is mandatory that states cover all categorically needy people receiving cash payments from the Aid to Families With Dependent Children (AFDC) program and most people receiving them from the Supplemental Security Income (SSI) program. It is optional for states to provide cash assistance to other groups, referred to hereafter as optional categorically needy groups, such as (1) poor families with unemployed parents or (2) children over 18 years of age who are still attending school. If the state extends AFDC coverage to these groups, it must extend Medicaid coverage as well. States not extending AFDC assistance, however, may still elect to offer Medicaid coverage to these optional categorically needy groups. States may also extend Medicaid to other optional categorically needy groups, such as people covered by AFDC or SSI who are not receiving payments because they are institutionalized.

In addition, states can extend Medicaid coverage to the medically needy--those who meet all criteria for categorically needy assistance with the exception of income and who have incurred relatively large medical bills. Since 1969, families whose monthly incomes are between the AFDC payment standard and 133.33 percent of that standard are eligible for assistance as medically needy. Others with incomes above that can become eligible for Medicaid if they have high medical expenses that reduce their incomes below the medically needy maximum. This situation is called spend-down.

With regard to depth of coverage, Medicaid regulations require participating states to cover the following basic services for all categorically needy recipients: (1) inpatient hospital services, (2) outpatient hospital services, (3) rural health clinic services, (4) laboratory and X-ray services, (5) services in a skilled nursing facility (SNF) for individuals 21 years of age and over, (6) physicians' services, (7) early periodic screening, diagnosis, and treatment for individuals under 21, (8) family planning services, (9) home health services, and (10) nurse-midwife services.

States can increase depth of coverage by offering any mix of specified optional services, including home and community-based services; inpatient psychiatric services for individuals under 21; services in intermediate care facilities (ICFs); prescribed drugs, dentures, and eyeglasses; physical therapy; dental services; private duty nursing services; and care provided by other licensed practitioners, such as optometrists and podiatrists.

Originally, states reimbursed providers based on reasonable costs or charges--the same concept used by most private health insurers. State Medicaid agencies essentially followed Medicare-based retrospective cost reimbursement principles. The Omnibus Reconciliation Act of 1980 gave states greater flexibility in reimbursing nursing homes, based on methods that produce payment rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. Additional flexibility in setting payment rates came with the passage of the Omnibus Budget Reconciliation Act of 1981, which relaxed the constraints that had tied hospital and physician payments to Medicare retrospective cost-reimbursement principles.

OBJECTIVES, SCOPE, AND METHODOLOGY

In August 1986, Senator Daniel Patrick Moynihan asked us to provide information on (1) why Medicaid costs have risen faster than the general rate of inflation and (2) why there are significant interstate variations in the average Medicaid payment per recipient. In doing our work, we reviewed and analyzed data from existing studies, reports, periodicals, and books. We relied primarily on five sources:

-- the Center for Health Economics Research's June 1984 report, sponsored by the Department of Health and Human

Services (HHS), The Evolution of State Medicaid Programs;[1]

-- the Urban Institute's 1986 report, Medicaid: The Trade-off Between Cost Containment and Access to Care;[2]

-- the Congressional Research Service's July 24, 1984, report, Medicaid: Legislative History, Program Description, and Major Issues;[3]

-- our March 9, 1983, report, Changing Medicaid Formula Can Improve Distribution of Funds to States;[4] and

-- the Health Care Financing Administration's (HCFA) August 1985 report, Health Care Financing Program Statistics: Analysis of State Medicaid Program Characteristics, 1984.

Because of the differing periods covered by the studies, we updated the information to the extent practicable, using (1) data provided by the National Governors' Association's State Medicaid Information Center and (2) unpublished HCFA data for fiscal years 1985-86 on state Medicaid program characteristics. We did not attempt to verify the accuracy of the HCFA unpublished data.

Arizona established an experimental Medicaid program in October 1982, under which the state contracts with prepaid health plans to provide most Medicaid services. None of the studies used in our analysis included data on the experimental Arizona program. Accordingly, we excluded Arizona from our analysis.

We did our review between August 1986 and February 1987. In accordance with the requester's wishes, we did not obtain official agency comments on a draft of this report. Except for not obtaining such comments, our work was done in accordance with generally accepted government auditing standards.

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[1]Jerry Cromwell et al. (Chestnut Hill, Mass.).

[2]John Holahan and Joel Cohen (Washington, D.C.).

[3]Report no. 84-140 EPW.

[4]GAO/GGD-83-27.

TRENDS IN MEDICAID SPENDING

Since its implementation, Medicaid spending has changed in two fundamental ways. First, the rapid growth characterizing the pre-1981 years of the program (see table 1) has essentially stopped. Second, the slowdown in spending has been accompanied by a shift in the nature of the program. An increasing proportion of Medicaid funds are spent on long-term care for elderly and chronically ill people rather than acute care for disabled and lower income adults and children. In fact, after the passage of the Omnibus Budget Reconciliation Act of 1981, real spending for the aged, blind, and disabled grew very slowly, but declined for other groups.

Concerning Medicaid spending, the following sections summarize (1) the primary factors contributing to its growth and (2) its shift to long-term care.

Table 1: Growth in Medicaid Spending, Fiscal Years 1966-87

Fiscal year	Expenditures		
	State	Federal	Total[a]
	(millions)		
1966[b]	$ 868	$ 789	$ 1,658
1967[b]	1,159	1,209	2,368
1968[b]	1,849	1,837	3,659[c]
1969[b]	1,890	2,276	4,166
1970[b]	2,235	2,617	4,852
1971	2,802	3,374	6,176
1972[d]	4,074	4,360	8,434
1973	4,113	4,998	9,111
1974	4,396	5,833	10,229
1975	5,578	7,060	12,637
1976	6,332	8,312	14,644
TQ[e]	1,752	2,354	4,106
1977	7,389	9,713	17,103
1978	8,269	10,680	18,949
1979	9,489	12,267	21,755
1980	11,231	14,550	25,781
1981	13,303	17,074	30,376
1982	14,931	17,514	32,446
1983	15,971	18,985	34,956
1984	16,414	20,061	36,475
1985	18,495	22,664	41,159
1986 (est.)	20,175	24,686	44,861
1987 (est.)	22,106	26,098	48,204

[a]Figures may not add due to rounding.

[b]Includes related programs that are not separately identified; for each successive year, however, a larger portion of the total represents Medicaid expenditures. As of January 1, 1970, federal matching was available only under Medicaid.

[c]Figures do not add in source document.

[d]ICFs were transferred from the cash assistance programs to Medicaid on January 1, 1972.

[e]Transitional quarter when the beginning of the federal fiscal year was moved from July 1 to October 1.

Source: Congressional Research Service, Medicaid: Legislative History, Program Description, and Major Issues (Report no. 84-140 EPW, July 24, 1984) and Medicaid: FY 87 Budget (IB 86046, updated Aug. 18, 1986).

Primary factors

Analyses prepared by HCFA in 1984 show that different factors dominated the different eras in Medicaid history. From the 1965 enactment of the program to 1971, program growth mirrored the speed with which states implemented their programs. Overall, expenditures grew at an average annual rate of 31 percent in these initial years (see table 2), with population--the number of Medicaid recipients covered--accounting for 14 percent of the growth. By 1971, Medicaid costs were about double the original estimates of what the program would cost.

Legislation enacted in 1971 and 1972 expanded Medicaid coverage. In particular, intermediate care facilities for the mentally retarded (ICF-MR) were added as a Medicaid benefit, and the definition of disability was broadened. Reflecting the importance of these two factors, population and utilization together accounted for 12 percent of the 22 percent annual rate of growth between fiscal years 1972 and 1975. Researchers attribute the rapid growth in ICFs-MR to the open-ended nature of the federal match, which gives states strong incentives to substitute Medicaid spending for other state and local spending. Forty-seven states now use Medicaid dollars to help pay for state institutional care for the mentally retarded.

Between fiscal years 1976 and 1980, both Medicaid utilization and population growth fell significantly; price was the major factor accounting for growth in spending. General inflation and more rapid price increases in the medical care sector, partially caused by increasing intensity of services, accounted for 80 percent of the growth in Medicaid spending during this era. Payments to nursing homes and ICFs-MR accounted for nearly 53 percent of the growth.

Finally, between fiscal years 1981 and 1983, Medicaid was characterized by increasing fiscal austerity measures in the states. During this time, spending attributable to utilization and population each fell at an average annual rate of 1 percent. Net annual growth of 10 percent was accounted for solely by price increases. A recent study[5] indicates that real spending growth (measured in constant rather than nominal dollars) essentially stopped between 1981 and 1984 and even declined in fiscal year 1982. According to another study,[6] Medicaid price increases not only explain all observed growth in program outlays but also reflect erosion of the real level of services purchased since 1975.

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[5]Medicaid (The Urban Institute).

[6]The Evolution of State Medicaid Programs (Center for Health Economics Research).

Table 2: Annual Growth in Medicaid Spending Attributable to Primary Factors

Era	Percentage attributable to: Utilization	Population	Price	Total annual growth
Calendar years				
1965-71	11	14	6	31
Fiscal years				
1972-75	5	7	10	22
1976-80	1	2	12	15
1981-83	-1	-1	12	10

Source: Congressional Research Service, Medicaid: Legislative History, Program Description, and Major Issues (Report no. 84-140 EPW, July 24, 1984).

Shift to long-term care

Medicaid spending has increasingly shifted from acute care for the disabled and poor to long-term care for the aged and chronically ill. This increasing emphasis on long-term care is illustrated by examination of the breakdown of Medicaid spending growth by eligibility and services. Between 1978 and 1984, acute care spending rose from $9.5 billion to $17.4 billion; long-term care spending rose from $8.2 billion to $17.0 billion (see table 3). Spending for the elderly and the blind and disabled during that period rose from $11.9 billion to $25.2 billion (calculated from figures in table 4); spending for AFDC recipients rose from $5.8 billion to $9.3 billion.

An October 1982 study by the American Enterprise Institute[7] found that most increases in Medicaid payments were for services for the aged and disabled. Between 1977 and 1980, 77 percent of the total growth in Medicaid payments was for these groups--36 percent for the disabled and 41 percent for other people over 65 years of age. In contrast, children under 21 years of age accounted for 10.0 percent of Medicaid spending increases, and adults in families with dependent children accounted for 11.8 percent.

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[7]Thomas W. Grannemann and Mark V. Pauly, Controlling Medicaid Costs: Federalism, Competition, and Choice (Washington, D.C.: American Enterprise Institute, Oct. 1982).

Table 3: Medicaid Payments for Acute and Long-Term Care, 1978-84

Year	Acute care	Long-term care	Total
	----------(billions)----------		
1978	$ 9.5	$ 8.2	$17.7
1979	10.6	9.6	20.2
1980	12.3	11.1	23.4
1981	14.6	13.1	27.7
1982	15.1	14.5	29.6
1983	16.6	15.7	32.4
1984	17.4	17.0	34.5

Source: John Holahan and Joel Cohen, Medicaid: The Trade-off Between Cost Containment and Access to Care, (Washington, D.C.: The Urban Institute, 1986).

Table 4: Medicaid Payments by Eligibility Category, 1978-84

Year	Elderly	Blind and disabled	AFDC adults	AFDC children
	----------(billions)----------			
1978	$ 6.3	$ 5.6	$2.6	$3.2
1979	7.2	6.7	2.9	3.4
1980	8.8	7.7	3.3	3.8
1981	10.1	9.6	3.8	4.1
1982	10.8	10.5	4.1	4.1
1983	12.1	11.4	4.4	4.4
1984	12.8	12.4	4.5	4.8

Source: John Holahan and Joel Cohen, Medicaid: The Trade-off Between Cost Containment and Access to Care, (Washington, D.C.: The Urban Institute, 1986).

INTERSTATE VARIATIONS IN MEDICAID SPENDING

Medicaid spending per recipient varied in fiscal year 1985 from a high of $3,384 in New York to a low of $821 in West Virginia (see table 5). The national average was $1,721. The percentage of Medicaid expenditures for the medically needy ranged from 0 in the 15 states without medically needy programs to 59 percent in North Dakota. The percentage of Medicaid recipients who were medically needy in states with programs ranged from less than one-half of 1 percent in Texas and Georgia to over 40 percent in North Dakota.

A 1984 study conducted for HHS by the Center for Health Economics Research compared state Medicaid programs based on three important program dimensions (mentioned earlier)--breadth of coverage, depth of coverage, and reimbursement to providers. The following sections summarize state differences based on these factors.

Table 5: Medicaid Spending per Recipient, by State, Fiscal Year 1985

State	Expenditures per recipient	Percentage of Expenditures for medically needy	Percentage of Recipients who are medically needy
New York	$3,384	54.9	22.9
District of Columbia	3,188	16.6	8.2
North Dakota	3,155	59.4	40.3
New Hampshire	3,104	7.1	10.4
Minnesota	2,804	37.7	26.4
South Dakota	2,776	a	a
Alaska	2,770	a	a
Connecticut	2,741	46.8	22.5
Massachusetts	2,739	51.4	20.8
Indiana	2,629	a	a
Rhode Island	2,475	15.7	11.7
Nevada	2,345	a	a
Colorado	2,148	a	a
Montana	2,032	23.6	10.2
Wisconsin	1,992	1.9	3.5
New Jersey	1,970	a	a
Idaho	1,958	a	a
North Carolina	1,885	46.8	21.2
Maine	1,874	4.2	6.0
Texas	1,858	0.2	0.4
Arkansas	1,819	7.9	12.9
Virginia	1,805	31.3	12.0
Kansas	1,805	47.0	22.0
Washington	1,792	4.2	5.7
Vermont	1,789	19.9	0.7
Nebraska	1,777	42.1	13.0
Maryland	1,775	45.7	18.8
Louisiana	1,743	3.0	2.6
Delaware	1,720	a	a
New Mexico	1,705	a	a
Oklahoma	1,705	21.7	10.2
Iowa	1,698	0.4	1.3
Ohio	1,691	a	a
Pennsylvania	1,678	14.8	14.0
Florida	1,678	a	a
Georgia	1,620	0.1	0.3
Tennessee	1,596	1.3	2.4
Oregon	1,560	0.6	1.5
Illinois	1,555	36.6	12.1
Hawaii	1,526	48.3	21.6
Utah	1,523	8.2	11.3
Missouri	1,474	a	a
Wyoming	1,412	a	a
Michigan	1,339	39.9	18.2
Kentucky	1,323	41.9	32.4
South Carolina	1,300	2.0	10.0
California	1,196	38.9	24.0
Alabama	1,188	a	a
Mississippi	915	a	a
West Virginia	821	4.2	4.7
National average	$1,721	27.6	15.6

[a]State does not have a medically needy program.

Source: HCFA, unpublished data (Baltimore, Md.).

Breadth of coverage

Income and asset criteria. States are allowed a great deal of latitude in setting Medicaid eligibility standards based on annual income (see table 6). For example, to qualify for Medicaid under AFDC eligibility rules, a family of three could have maximum annual income ranging from $1,416 in Alabama (15.5 percent of the federal poverty level) to $8,880 in Alaska (77.9 percent of that state's poverty level). Similarly, to qualify for Medicaid under medically needy criteria, a family of three could have maximum annual income ranging from $2,496 in Tennessee (27.3 percent of the federal poverty level) to $9,900 in California (108.6 percent of the federal poverty level). Finally, to qualify for Medicaid under SSI eligibility rules, an individual could have maximum income ranging from $4,032 in 22 states to $7,260 in Alaska (108.4 percent of that state's poverty level).

Less variation occurs in asset limits. For example, asset limits for AFDC are uniform for all states--a home of any value, an automobile worth up to $1,500, and any other real or personal property essential for day-to-day living worth up to $1,000. SSI maximum asset limits are also uniform: a home of any value, an automobile worth up to $4,500, personal effects worth up to $2,000, liquid assets worth $1,700 for individuals and $2,550 for couples, a burial space, up to $1,500 for burial expenses, and life insurance with face value up to $1,500. Under certain circumstances, states can impose more stringent asset limits for SSI beneficiaries.

Asset limits for medically needy programs vary by state, but must be (1) at least as liberal as the highest limits allowed for cash assistance recipients in the state and (2) the same for all covered groups. In 1984, the asset limits for a family of two ranged from $2,250 in 21 states to $9,500 in North Dakota.

Table 6: Medicaid Eligibility Standards
Based on Annual Income (as of December 1986)

State	AFDC family of three[a]	Medically needy family of three[a]	SSI independent individual[b]
Alabama	$1,416	$ [c]	$4,752
Alaska	8,880	[c]	7,260
Arkansas	2,304	3,100	4,032
California	7,404	9,900	6,396
Colorado	5,052	[c]	4,728
Connecticut	6,060	7,300	5,780
Delaware	3,720	[c]	4,032
District of Columbia	4,200	5,820	4,212
Florida	3,024	4,092	4,032
Georgia	3,072	4,104	4,032
Hawaii	5,616	5,700	4,091
Idaho	3,648	[c]	4,656
Illinois	4,092	5,496	[d]
Indiana	3,072	[c]	4,032
Iowa	4,572	6,096	4,032
Kansas	4,524	5,520	4,032
Kentucky	2,364	3,204	4,032
Louisiana	2,280	3,096	4,032
Maine	6,432	6,300	4,
Maryland	4,140	4,908	4,032
Massachusetts	5,712	7,896	5,578
Michigan	5,388	6,252	4,366
Minnesota	6,384	6,384	4,452
Mississippi	4,416	[c]	4,032
Missouri	3,348	[c]	4,032
Montana	3,984	4,848	4,032
Nebraska	4,200	5,400	4,692
Nevada	3,420	[c]	4,469
New Hampshire	4,668	5,604	4,200
New Jersey	4,848	6,492	4,407
New Mexico	3,096	[c]	4,032
New York	5,964	7,300	4,895
North Carolina	2,952	3,996	4,032
North Dakota	4,452	5,220	4,032
Ohio	3,624	[c]	4,032
Oklahoma	3,720	5,004	4,752
Oregon	4,764	6,348	4,052
Pennsylvania	4,380	5,100	4,421
Rhode Island	5,292	7,600	4,698
South Carolina	4,560	3,192	4,032
South Dakota	4,392	[c]	4,212
Tennessee	1,860	2,496	4,032
Texas	2,208	3,204	4,032
Utah	8,316	6,012	4,152
Vermont	6,372	7,296	4,700
Virginia	3,492	4,300	4,032
Washington	5,904	6,624	4,368
West Virginia	2,988	3,480	4,032
Wisconsin	6,528	7,692	5,252
Wyoming	4,320	[c]	4,272

[a]Federal poverty level, $9,120, except for AFDC families in Alaska (family of three, $11,400, and family of one, $6,700) and Hawaii (family of three, $10,400 and family of one, $6,170).

[b]Federal poverty level, $5,360. Includes basic federal payment plus state supplemental amount where appropriate.

[c]State does not have a medically needy program.

[d]Illinois budgets each case individually.

Source: National Governors' Association, State Medicaid Information Center, December 1986.

Medicaid recipients per 100 residents in poverty. For every 100 residents living below the federal poverty level, as shown in table 7, South Dakota provided Medicaid coverage to 17 residents. Another eight states--Idaho, Florida, Nevada, North Dakota, Alabama, Texas, Utah, and Wyoming--had fewer than 25 Medicaid recipients per 100 residents below the poverty level. At the other end of the spectrum, Hawaii had 104 Medicaid recipients for every 100 residents living in poverty, followed by California, Rhode Island, and Michigan, which had over 70 Medicaid recipients for every 100 residents living in poverty.

Table 7: Medicaid Recipients per 100 Residents Below the Federal Poverty Level, Fiscal Year 1982

State	Number	State	Number
Hawaii	104	Iowa	34
California	83	Kentucky	34
Rhode Island	77	Oregon	34
Michigan	72	Mississippi	33
Massachusetts	69	New Hampshire	33
Wisconsin	67	Georgia	31
Pennsylvania	64	Louisiana	31
New York	60	South Carolina	30
Vermont	60	Virginia	29
Illinois	58	Nebraska	28
Maine	53	Tennessee	28
New Jersey	53	Arkansas	27
District of Columbia	51	Colorado	27
Maryland	50	Indiana	25
Minnesota	49	New Mexico	25
Ohio	47	North Carolina	25
Connecticut	45	Alabama	24
Kansas	38	Florida	24
Alaska	37	Nevada	22
Oklahoma	37	North Dakota	22
West Virginia	37	Utah	21
Delaware	36	Texas	20
Missouri	36	Wyoming	20
Washington	35	Idaho	18
Montana	34	South Dakota	17

Source: HCFA, Health Care Financing Program Statistics: Analysis of State Medicaid Program Characteristics, 1984 (Baltimore, Md., 1984), pp. 154-55.

Categorically needy groups. The mix of categorically needy groups varies significantly across the states. Nationally, AFDC cash enrollees composed 66.3 percent of total enrollees in fiscal year 1985; SSI cash enrollees composed 21.8 percent; noncash enrollees made up the remaining 11.9 percent (see table 8). In Hawaii and Illinois, however, AFDC enrollees composed about 85 percent of total enrollees, whereas in Arkansas and South Carolina, they composed only about 44 percent. About 75 to 80 percent of enrollees were AFDC-cash recipients in Connecticut, Kansas, Maryland, Michigan, and Minnesota. Alabama and Arkansas, on the other hand, had the highest percentage of SSI-cash recipients. In general, such southern states as Alabama, Arkansas, South Carolina, and Tennessee had smaller AFDC-based programs than such industrial states as Illinois, Michigan, Ohio, and Pennsylvania. In 1985 the largest programs were in California and New York, with about 68 percent of enrollees receiving AFDC payments in California and 73 percent in New York.

Table 8: Mix of Categorically Needy Groups, Fiscal Year 1985[a]

State	AFDC-cash	SSI-cash	Noncash
Alabama	48.9%	41.5%	9.5%
Alaska	68.4	18.0	13.6
Arkansas	43.9	44.5	11.6
California	68.3	28.9	2.8
Colorado	46.7	24.0	29.3
Connecticut	79.3	8.3	12.4
Delaware	67.2	18.1	14.7
District of Columbia	70.0	18.3	11.7
Florida	55.0	33.0	12.0
Georgia	52.6	32.2	15.2
Hawaii	85.2	14.2	0.5
Idaho	62.9	8.2	28.9
Illinois	84.5	12.4	3.1
Indiana	65.6	9.1	25.3
Iowa	65.0	13.5	21.5
Kansas	77.3	18.6	4.1
Kentucky	62.5	34.3	3.3
Louisiana	59.2	31.2	9.6
Maine	55.6	18.0	26.4
Maryland	80.1	18.2	1.8
Massachusetts	63.3	28.2	8.5
Michigan	80.8	12.0	7.1
Minnesota	78.3	12.1	9.6
Mississippi	54.6	36.9	8.5
Missouri	61.2	8.9	29.8
Montana	59.1	16.7	24.2
Nebraska	68.1	17.3	14.6
Nevada	54.8	27.0	18.2
New Hampshire	53.4	13.6	33.0
New Jersey	68.2	16.5	15.2
New Mexico	64.7	28.4	6.9
New York	73.4	21.7	4.9
North Carolina	68.5	20.9	10.6
North Dakota	73.2	23.9	2.9
Ohio	73.6	9.4	17.0
Oklahoma	60.2	24.3	15.5
Oregon	63.3	11.6	25.2
Pennsylvania	63.8	15.5	20.6
Rhode Island	64.6	19.8	15.6
South Carolina	43.5	29.9	26.6
South Dakota	51.4	24.8	23.9
Tennessee	44.9	36.6	18.5
Texas	52.8	33.5	13.8
Utah	64.8	10.4	24.8
Vermont	52.1	19.7	28.2
Virginia	66.0	28.2	5.9
Washington	68.4	2.9	28.6
West Virginia	65.5	20.6	13.9
Wisconsin	62.6	14.5	22.9
Wyoming	71.7	14.1	14.2
U.S. total	66.3%	21.8%	11.9%

[a]Percentages may not add due to rounding.

Source: HCFA, unpublished data (Baltimore, Md.).

Optional groups. In 1986, as shown in table 9,

-- 26 states provided Medicaid coverage to individuals who were eligible for AFDC or SSI but were not receiving those benefits;

-- 39 states provided Medicaid coverage to individuals who would be eligible for AFDC or SSI if they were not in a Medicaid-reimbursable medical institution or ICF;

-- 12 states extended Medicaid coverage to individuals who would be eligible for AFDC if their work-related child care costs were paid from their earnings rather than by a state agency;

-- 9 states extended Medicaid coverage to members of a family with an unemployed parent even though AFDC is not available to them under the state's AFDC plan; and

-- 37 states had medically needy programs to provide Medicaid coverage to individuals who (1) met all but the income criteria for one of the categorically needy groups and (2) had relatively large medical bills that reduced their incomes below the medically needy maximum.

Six states (Hawaii, Minnesota, New York, Pennsylvania, Rhode Island, and Wisconsin) provided coverage to all five major optional groups of beneficiaries.

In contrast, Indiana and Missouri covered none of the optional groups and 13 states (Alabama, California, Delaware, Kansas, Illinois, Michigan, Mississippi, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, and Wyoming) covered only one of the groups.

Table 9: Coverage for Optional Medicaid Groups, 1986

State	Medically needy	Families with an unemployed parent	Child care spend-down	Eligible for but not receiving AFDC/SSI	Institutional SSI/AFDC
Alabama					X
Alaska				X	X
Arkansas	X				X
California	X				
Colorado			X	X	X
Connecticut	X			X	X
Delaware					X
District of Columbia	X		X	X	X
Florida	X[a]	X			X
Georgia	X				X
Hawaii	X	X	X	X	X
Idaho				X	X
Illinois	X				
Indiana					
Iowa	X			X	X
Kansas	X				
Kentucky	X	X			
Louisiana	X				X
Maine	X			X	X
Maryland	X			X	X
Massachusetts	X			X	X
Michigan	X				
Minnesota	X	X	X	X	X
Mississippi					X
Missouri					
Montana	X		X	X	X
Nebraska	X				
Nevada					X
New Hampshire	X			X	X
New Jersey	X[a]	X		X	X
New Mexico					X
New York	X	X	X	X	X
North Carolina	X			X	
North Dakota	X				
Ohio			X		X
Oklahoma	X		X	X	X
Oregon	X			X	X
Pennsylvania	X	X	X	X	X
Rhode Island	X	X	X	X	X
South Carolina	X				X
South Dakota					X
Tennessee	X				X
Texas	X				X
Utah	X		X	X	X
Vermont	X			X	X
Virginia	X			X	X
Washington	X			X	X
West Virginia	X			X	
Wisconsin	X	X	X	X	X
Wyoming	—	—	—	—	X
Total states	37	9	12	26	39

[a]According to the National Governors' Association, Florida and New Jersey implemented medically needy programs during 1986.

Source: HCFA, unpublished data (Baltimore, Md.).

Depth of coverage

Service limits. States may attempt to reduce utilization and, potentially, depth of coverage by imposing limits on mandatory and optional services. Specifically, states may limit the number of days or visits allowed for a specified period of time, require recipients to obtain prior authorization from the Medicaid agency before utilizing specified services, or require copayments for optional services. States frequently limit inpatient hospital, outpatient, and physician services. The most important limit is probably on hospitalization. In 1986, as shown in table 10, 10 states limited Medicaid recipients' days of hospital care--from 12 to 60 days. Similarly, 11 states had placed limits on the number of outpatient hospital visits, ranging from 3 to 48 visits per year. Finally, 11 states had placed yearly limits on the number of physician office visits (ranging from 4 to 24) or the number of visits allowed in any setting other than inpatient hospital. Nineteen states required prior authorization from the state Medicaid agency before specific hospital procedures could be provided to Medicaid recipients.

Table 10: Limits on Selected Medicaid Services, 1986

State	Inpatient hospital (days)	Outpatient hospital (visits)	Prior authorization required[a]	Physician office visits
Alabama	12	3	X	12[b]
Alaska			X	
Arkansas		18	X	18
California			X	
Colorado				
Connecticut				
Delaware				
District of Columbia				
Florida	45			
Georgia			X	
Hawaii		48		
Idaho	40	6		
Illinois				
Indiana			X	
Iowa			X	
Kansas				12
Kentucky	14[c]			
Louisiana			X	12[b]
Maine				
Maryland			X	
Massachusetts				
Michigan			X	
Minnesota			X	
Mississippi	15	6		12[b]
Missouri		24		
Montana				
Nebraska				
Nevada				24
New Hampshire		12		18[b]
New Jersey			X	
New Mexico			X	
New York				
North Carolina		24	X	24[b]
North Dakota				
Ohio				
Oklahoma				4
Oregon	18			
Pennsylvania		12		
Rhode Island			X	
South Carolina		18	X	18[b]
South Dakota				
Tennessee	14	30		24
Texas	30[c]			
Utah			X	
Vermont			X	
Virginia	21			
Washington				
West Virginia	60			
Wisconsin			X	
Wyoming				
Total	10	11	19	11

[a]Specific inpatient hospital procedures.

[b]Limit applies to all physician visits other than inpatient hospital.

[c]Per illness or admission.

Source: HCFA, unpublished data (Baltimore, Md.).

Payment by eligibility group. States may also limit depth of coverage by not covering all services to optional groups, such as the medically needy and noncash AFDC and SSI beneficiaries. Because the medically needy are, by definition, intensive users of medical care, states that extend coverage to them are likely to experience higher total payments per enrollee. In fact, as shown in table 11, New York spent $6,871 per recipient for optional groups in 1982 compared with $4,940 per SSI-cash enrollee and $864 per AFDC-cash enrollee. Similarly, West Virginia spent $1,580 per recipient for its optional groups, $1,042 per SSI-cash enrollee, and $463 per AFDC-cash enrollee.

Table 11: Interstate Variations in Medicaid Payments, by Groups, 1982

AFDC-cash		SSI-cash		Optional groups[a]	
State	Cost per enrollee	State	Cost per enrollee	State	Cost per enrollee
Nevada	$1,064	Illinois	$8,370	Nevada	$9,178
Montana	997	Minnesota	7,231	Minnesota	8,623
District of Columbia	985	Utah	5,195	Ohio	8,060
North Dakota	983	Colorado	5,024	New Hampshire	7,713
Kansas	957	New York	4,940	Wyoming	7,536
Wyoming	917	Arkansas	4,834	Louisiana	7,393
Minnesota	869	District of Columbia	4,615	South Carolina	7,386
New York	864	Nevada	4,357	Mississippi	7,109
Iowa	815	Nebraska	4,241	Texas	7,070
Idaho	778	Indiana	4,049	Indiana	6,941
Nebraska	770	Kansas	3,885	New York	6,871
Texas	762	Ohio	3,825	Massachusetts	6,868
Tennessee	756	Iowa	3,661	Tennessee	6,790
Ohio	720	South Dakota	3,600	Alabama	6,456
Oregon	704	Rhode Island	3,567	North Carolina	6,407
Massachusetts	703	Vermont	3,248	South Dakota	6,295
South Dakota	691	Pennsylvania	3,213	Georgia	6,262
Maine	687	Wisconsin	3,158	Wisconsin	6,215
California	672	Montana	3,133	Connecticut	6,054
Wisconsin	668	Wyoming	3,016	Rhode Island	5,959
Washington	667	Hawaii	2,897	Florida	5,910
Illinois	665	Michigan	2,882	Illinois	5,806
Alaska	651	Delaware	2,878	Arkansas	5,781
Georgia	644	Massachusetts	2,698	Idaho	5,779
Indiana	642	New Jersey	2,667	Oklahoma	5,660
Louisiana	641	North Carolina	2,478	Michigan	5,603
Michigan	635	Texas	2,392	New Mexico	5,553
Delaware	632	Oklahoma	2,380	Pennsylvania	5,551
New Mexico	628	Maryland	2,374	Virginia	5,545
Maryland	624	Virginia	2,356	New Jersey	5,441
Colorado	621	Washington	2,354	Iowa	5,264
Vermont	620	Louisiana	2,343	Nebraska	4,990
Oklahoma	620	North Dakota	2,198	Delaware	4,693
Rhode Island	601	Georgia	2,103	North Dakota	4,559
Utah	591	Maine	2,020	Oregon	4,554
Hawaii	589	New Mexico	1,935	Hawaii	4,379
Virginia	587	California	1,931	Washington	4,343
Arkansas	580	Arkansas	1,926	Kansas	4,235
Pennsylvania	560	Tennessee	1,729	Maryland	4,152
New Hampshire	559	Florida	1,681	Maine	4,136
Alabama	550	Connecticut	1,574	Utah	4,079
Florida	547	Kentucky	1,490	Colorado	3,868
Missouri	533	New Hampshire	1,467	California	3,468
North Carolina	531	South Carolina	1,424	Vermont	3,467
Connecticut	512	Alabama	1,362	District of Columbia	3,227
Kentucky	488	Oregon	1,242	Missouri	3,162
West Virginia	463	Mississippi	1,224	Kentucky	2,381
Mississippi	450	West Virginia	1,042	West Virginia	1,580
South Carolina	430	Missouri	1,031		
[b]		Idaho	705	[c]	

[a]Includes noncash AFDC and SSI beneficiaries and medically needy.

[b]Data not reported for New Jersey.

[c]Data not reported for Montana, Alaska.

Source: Jerry Cromwell et al., The Evolution of State Medicaid Programs (Chestnut Hill, Mass.: Center for Health Economics Research, June 1984), pp. 6-14.

Reimbursement to providers

Reimbursement methods. Under a retrospective payment system, providers are reimbursed for the actual allowable costs they incur. Such systems typically entail after-the-fact reporting of costs; a settlement is made based on the interim rates paid by Medicaid during the period and the actual allowable costs as evidenced by the provider's cost reports. Prospective payment systems, on the other hand, set payment rates in advance and allow the facility to keep all or part of the difference between the rate and actual costs. If costs exceed the payment rate, the provider suffers a loss.

HCFA unpublished data show that in 1986 no states were applying retrospective payment methods across all providers, and 19 states did not pay any providers on a provider-specific cost or charge basis. In addition, relatively few states have adhered to retrospective principles in long-term care payment, as shown in table 12. Only 3 states paid ICFs retrospectively; 9 paid ICFs-MR retrospectively; and 4 paid SNFs retrospectively. On the other hand, the trend toward prospective payment for hospitals is slower. As of 1986, 16 states reimbursed hospitals retrospectively. Finally, 15 states were reimbursing physicians based on Medicare customary, prevailing, or reasonable reimbursement principles rather than using fee schedules or other methods to limit payments. This methodology limits reimbursement to the lowest of (1) a physician's actual charge, (2) the physician's median charge in a recent prior period (customary), or (3) the 75th percentile of charges in that same period (prevailing). Any prevailing charges at or under the 75th percentile are considered "reasonable."

Table 12: States Using Retrospective or Customary, Prevailing, or Reasonable Reimbursement Principles, 1986

State	Type of provider				
	SNF	ICF	ICF-MR	Hospitals	Physicians
Alabama					X
Alaska					X
Arkansas					
California					
Colorado					
Connecticut				X	
Delaware				X	
District of Columbia					
Florida					
Georgia					
Hawaii				X	X
Idaho	X	X	X		
Illinois					
Indiana					
Iowa					X
Kansas					X
Kentucky				X	X
Louisiana				X	X
Maine	X				
Maryland					
Massachusetts	X	X			
Michigan					
Minnesota				X	
Mississippi					
Missouri					
Montana			X	X	
Nebraska					X
Nevada					
New Hampshire	X				
New Jersey			X		
New Mexico			X		X
New York					
North Carolina					
North Dakota			X	X	X
Ohio				X	X
Oklahoma					X
Oregon				X	
Pennsylvania				X	
Rhode Island					
South Carolina			X	X	
South Dakota				X	
Tennessee		X	X		X
Texas				X	X
Utah					
Vermont			X		
Virginia			X		
Washington					
West Virginia				X	
Wisconsin					
Wyoming	—	—	—	X	X
Total	4	3	9	16	15

Source: HCFA, unpublished data (Baltimore, Md.).

Payments for inpatient care. Medicaid payments to hospitals averaged about $369 per day in fiscal year 1985 (as shown in table 13), ranging from about $160 per day in Nebraska to about $533 per day in the District of Columbia. The average daily payment to SNFs was about $41 per day, ranging from about $22 in Arkansas to about $80 in Iowa. The average daily payment for ICFs was about $30, ranging from about $18 in Iowa to about $44 in New Hampshire and New Jersey. Finally, payments to ICFs-MR averaged about $80 a day, but ranged from about $34 in New Jersey to over $144 a day in the District of Columbia.

Table 13: Average Medicaid Payments per Inpatient Day, Fiscal Year 1985

State	Hospital	SNF	ICF	ICF-MR
Alabama	$331.63	$ a	$ a	$ a
Alaska	a	a	a	a
Arkansas	395.48	22.43	21.28	88.62
California	a	32.53	23.63	47.79
Colorado	348.22	28.48	28.48	84.77
Connecticut	429.42	48.37	35.90	a
Delaware	a	a	a	a
District of Columbia	532.99	a	a	144.50
Florida	373.04	33.97	33.97	102.11
Georgia	482.76	25.75	24.49	107.32
Hawaii	a	a	a	a
Idaho	471.78	31.57	30.85	85.73
Illinois	413.00	28.43	23.22	77.18
Indiana	313.00	42.02	30.93	44.25
Iowa	248.00	80.06	18.44	89.00
Kansas	306.40	26.94	21.56	39.87
Kentucky	359.26	45.05	27.78	93.94
Louisiana	372.51	37.54	24.10	67.66
Maine	246.72	53.18	36.48	98.02
Maryland	445.04	39.74	39.74	99.31
Massachusetts	389.00	48.09	31.07	126.00
Michigan	454.58	28.79	28.79	51.82
Minnesota	310.86	45.72	34.85	72.45
Mississippi	380.00	32.53	26.61	49.45
Missouri	313.62	34.61	29.54	97.25
Montana	392.72	32.50	32.50	a
Nebraska	160.47	44.06	21.42	78.31
Nevada	360.45	47.39	39.58	132.17
New Hampshire	a	79.00	44.00	a
New Jersey	a	49.21	44.08	34.20
New Mexico	485.91	67.01	37.16	90.46
New York	a	a	a	a
North Carolina	289.00	43.72	29.54	110.40
North Dakota	a	a	a	a
Ohio	465.75	38.73	35.91	70.46
Oklahoma	307.90	36.00	30.50	40.00
Oregon	342.64	42.25	26.01	78.45
Pennsylvania	280.11	39.80	31.96	100.06
Rhode Island	335.00	40.35	37.52	114.38
South Carolina	428.69	31.93	31.93	a
South Dakota	269.53	27.86	24.45	63.92
Tennessee	501.52	39.55	24.89	72.74
Texas	414.68	32.16	21.75	48.34
Utah	380.00	40.75	26.86	58.23
Vermont	307.86	38.21	38.21	103.60
Virginia	379.13	62.56	33.20	82.52
Washington	350.51	a	a	a
West Virginia	407.27	44.15	29.62	40.66
Wisconsin	328.60	38.47	30.78	61.26
Wyoming	401.88	a	a	a
Simple average	$369.21	$41.01	$30.33	$80.19

[a]Data not available.

Source: HCFA, unpublished data (Baltimore, Md.).

Physician fees. Concerning physician payment, unpublished 1986 HCFA data show that some states paid well above the national average of $11.93 for an office visit, $341.31 for an appendectomy, and $473.11 for obstetrical care (prenatal care and delivery), as shown in table 14. Alaska, at $28.41, and the District of Columbia, at $20.00, paid the most for office visits. Nevada paid the most for an appendectomy, at $673.72; Massachusetts paid the most for obstetrical care, at $1,027. The states that paid the least to physicians include Florida, New Hampshire, New Jersey, New York (except for obstetrical care, in which it exceeds the national average), Vermont, Virginia, and West Virginia. Massachusetts, which had one of the lowest physician fees for obstetrical care in fiscal year 1984, raised its fee to $1,027 in fiscal year 1986 in an attempt to convince more obstetricians to accept Medicaid patients.

Table 14: Maximum Allowable Physician Fees for Selected Procedures, 1986[a]

State	Brief office exam[b] (general practitioner)	Appendectomy (specialist)	Obstetrical care[c] (specialist)
Alabama	$11.70	$405.00[d]	$450.00[d]
Alaska	28.41		
Arkansas	12.00	275.00	500.00
California	11.04	353.68	519.60
Colorado	11.75	280.00[d]	392.00[d]
Connecticut	8.80		
Delaware	12.66	390.35	321.78
District of Columbia	20.00	315.00	600.00
Florida	10.00	197.50	310.00
Georgia	15.60	399.50	606.38
Hawaii	11.58	453.66	416.54
Idaho	10.50	336.40	450.00
Illinois	11.50	270.00	405.00
Indiana	17.30[d]	533.00[d]	533.00[d]
Iowa			
Kansas	15.00	268.00	459.40[d]
Kentucky	12.00	401.60	
Louisiana	10.69	411.16	516.30
Maine	8.00	217.50	500.00
Maryland	10.50	202.00	525.00
Massachusetts	8.00	233.00	1,027.00
Michigan	7.75	271.50	409.75
Minnesota	15.75	520.00	455.00
Mississippi	11.55	295.05	446.25
Missouri	10.00	220.00	335.00
Montana	11.30	342.88	577.49
Nebraska	12.40	453.90	597.70
Nevada	15.82	673.72	708.57
New Hampshire	6.00	225.00	214.00
New Jersey	7.00	211.00	236.00
New Mexico	10.40	396.15	354.78
New York	7.00	160.00	550.00
North Carolina	11.40	378.00	454.75
North Dakota	8.20	449.05	d
Ohio	12.00	337.50	d
Oklahoma	11.00	500.00	725.00
Oregon	11.07	387.98	501.93
Pennsylvania	13.00	301.50	312.50
Rhode Island	14.00	205.00	350.00
South Carolina	9.50	307.40	485.00
South Dakota	12.00	345.00	325.00
Tennessee	18.00[d]	449.50[d]	650.00[d]
Texas			
Utah	9.92	430.12	576.35
Vermont	8.00	225.00	350.00
Virginia	6.30	236.25	262.50
Washington	13.92	290.23	535.43
West Virginia	10.00	230.00	255.00
Wisconsin	16.23	432.85	590.22
Wyoming	16.30	483.50	553.50
Simple average	$11.93	$341.31	$473.11

[a]For states not reporting 1986 rates, HCFA used rates as reported in a previous year.

[b]Brief office visit for evaluation and treatment of an established patient.

[c]Total obstetrical care including antepartum care, vaginal delivery, and postpartum care.

[d]Not indicated on source document.

Source: HCFA, unpublished data (Baltimore, Md.).

NEW YORK'S MEDICAID SPENDING

As shown in table 15, New York, with a little over 10 percent of the nation's Medicaid recipients, accounted for about 20 percent of Medicaid payments in fiscal year 1985.

Table 15: New York's Medicaid Recipients and Payments as a Percentage of the Nation's, Fiscal Year 1985

Type of recipient	New York's recipients as a percentage of the nation's	New York's payments as a percentage of the nation's
Nation's Medicaid	10.3	20.2
Medically needy	15.1	40.2
SSI-aged	11.2	26.8
SSI-blind	5.0	21.2
SSI-disabled	9.9	18.1
AFDC under 21	10.1	15.3
AFDC adults	8.7	11.7

Source: HCFA, unpublished data (Baltimore, Md.).

New York devoted a greater percentage of its Medicaid payments to the medically needy--nearly 55 percent--than the national average of 27.6 percent (see table 16). In New York, nearly 23 percent of recipients were medically needy compared with a national average of 15.6 percent. The average Medicaid payment to medically needy recipients in New York was about $8,100 in 1985 compared with $3,035 across all states with medically needy programs.

New York also spent much more per SSI recipient. In 1985, payments per aged recipients were over $11,000; per blind, over $13,200; and per disabled, over $8,200. Payments for AFDC recipients, both children and adults, were lower although still in excess of the national average. Additional details are provided in table 16.

Table 16: New York's Medicaid Payments per Recipient Compared With National Averages, 1985

Type of recipient	Payments per recipient			
	New York	National averages	New York	National averages
Categorically needy	$ 1,981	$1,425	45.1%	72.4%[a]
Medically needy	8,099	3,035	54.9	27.6
SSI-aged	11,059	4,605	49.8	37.8
SSI-blind	13,201	3,118	0.7	0.7
SSI-disabled	8,238	4,499	31.6	35.2
AFDC under 21	685	453	8.9	11.8
AFDC adults	1,150	861	7.3	12.7
Other	920	658	1.7	2.1

[a]Percentages may not add due to rounding.

Source: HCFA, unpublished data (Baltimore, Md.).

New York exceeded the national average in terms of the percentage of Medicaid payments for SNF care, home health care, and mental health. In New York, 23 percent of payments were for SNFs compared with 14 percent nationally. New York had 9 percent of payments for both home health and mental health, whereas, nationally, states averaged 3 percent for each. New York spent much less on ICFs (excluding ICFs-MR)--4 percent of payments versus 17 percent nationally--and half the national average on physician services and prescription drugs.

In 1982, New York spent slightly more (4.9 percent) of its total Medicaid expenditures on administrative and training costs than the national average (4.6 percent) and, in 1985, twice as much as the national average (0.2 percent versus 0.1 percent) to prevent fraud and abuse of Medicaid services. New York spent about $7.78 per recipient to prevent fraud and abuse in 1985, compared with an average of $2.16 per recipient nationally.

In an October 1986 report on Medicaid fraud control units,[8] we reported that New York accounted for about $17.4 million of the approximately $47 million (37 percent) spent on Medicaid fraud control units in fiscal year 1985. During the same year, New York accounted for 98 of the 440 convictions (22 percent), 29 of the 108 providers receiving jail sentences (27 percent), about $285,000 of the $1,427,000 in fines imposed (20 percent), none of the about $875,000 in fines collected, and about $1,133,000 of the $3,074,000 in restitution collected (37 percent).

REASONS FOR INTERSTATE VARIATIONS

Researchers have examined Medicaid spending as the outcome of three interrelated public expenditure decisions:

-- what the overall tax rate will be to finance all publicly provided goods and services,

-- how tax revenues will be split between Medicaid and other programs, and

-- how the Medicaid share will be spent.

Concerning Medicaid expenditures, should a state maximize eligibility and limit service coverage or cover fewer of its poor but offer them a more comprehensive set of benefits? What are appropriate methods and rates of payment for providers?

To explain how states make Medicaid spending decisions, researchers have developed public expenditure models of the demand for and supply of Medicaid services. These models have been used to analyze the relative importance of certain variables--chiefly economic factors, political preferences, and demographics--in accounting for interstate spending variations. In general, differences in fiscal resources and political attitudes about health care for the poor are the major causes of interstate variations. For example, economic factors--such as state size, wealth, and federal cost-sharing--and political factors--such as willingness to redistribute tax funds to the poor--explain disparities in the Medicaid programs.

In our 1983 report,[9] we found that the current matching formula, which was intended to equalize resource variations from state to state, does not fully offset the advantages of

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[8]Medicaid: Results of Certified Fraud Control Units (GAO/HRD-87-12FS, Oct. 21, 1986).

[9]Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, Mar. 9, 1983).

wealthier states. Poorer states, which must still make a greater tax effort to provide programs comparable with those of wealthier states, tend to establish smaller Medicaid programs. We found that even equality of resources, however, would not fully reduce benefit disparities; social and political attitudes toward welfare, in general, and health care for the poor, specifically, also shape Medicaid programs.

A 1980 quantitative analysis of Medicaid spending[10] concluded that economic factors such as tax burdens and income, rather than interregional differences in attitudes toward the poor, explain much of the interstate variations. The study highlighted two economic determinants of Medicaid spending. First, the tax burden borne by state taxpayers is inversely related to expenditures. In other words, higher tax burdens tend to discourage state Medicaid spending. Specifically, the study results suggest that for every 1.0 percent rise in state tax burdens, states would reduce Medicaid spending by 0.8 percent. This sensitivity to state tax burdens implies that federal policy can effectively influence the level of Medicaid benefits provided by altering state taxpayer burdens through changes in the matching formula. Second, the income of state taxpayers is positively related to Medicaid spending. States with higher taxpayer incomes tend to provide greater benefits. Moreover, a 1 percent increase in income results in a more than proportionate increase in spending, especially for poor children and adults.

Three other potentially significant relationships were also emphasized in the study. First, it appears that people in states with high medical care prices are more willing to provide Medicaid benefits to relatively more recipients. Second, there is an inverse relationship between Medicaid benefits and number of recipients across states. Those states with relatively large numbers of poor tend to have relatively more recipients but lower benefit levels; this, in effect, spreads medical care more thinly over a broader population. Finally, the number of Medicaid recipients was directly related to the number of hospital beds and physicians per capita, suggesting that taxpayers may be more generous when they believe their own use of medical resources will not be crowded out by the poor.

A 1986 report[11] employs a different model of public expenditure decision making. This model also assumes that

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[10]Thomas W. Grannemann, "Reforming National Health Programs for the Poor," in National Health Insurance, ed. Mark V. Pauly (Washington, D.C.: American Enterprise Institute, 1980), pp. 104-36.

[11]Medicaid (The Urban Institute).

Medicaid spending depends on factors such as a state's income or ability to pay; state taxpayer burdens, which are influenced by the federal matching rate; demographic characteristics of potential eligibles; and the availability of providers. In addition, however, the model explicitly includes a regional variable to analyze differences in the states' preferences for spending public funds on in-kind welfare programs.

The study strongly suggests that spending differences are related to state income levels. The higher the state's income, the greater the ability to pay for Medicaid services. The study results also show that states with higher federal matching rates (lower taxpayer burdens) have higher levels of Medicaid spending. Contrary to expectations, however, matching rates appear to be less important determinants of Medicaid spending than each state's ability to pay. Many wealthier states were apparently willing to support generous Medicaid programs even at relatively high cost to the state taxpayers, while poorer states were unwilling to do so even though their share of the cost would have been relatively low. In other words, federal subsidies to poorer states are not sufficient to encourage them to spend on Medicaid at the same level as wealthier states.

Perhaps the most significant finding, however, was that political philosophy is also an important determinant of interstate variations. Results indicated wide regional spending variations that were not explained by differences in income, state taxpayer burdens, and demographics. All other factors held constant, the South and West consistently showed the lowest levels of spending, and the East showed the highest. Specifically, per capita spending in the West and South was about 25 and 42 percent less, respectively, than the Midwest; per capita spending in the East exceeded the Midwest by about 28 percent. This indicates that substantial interstate variations relate to a state's willingness to spend more on Medicaid than can be explained by economic factors alone. The wide latitude in federal regulations allows the states to express these political differences in the structure of their Medicaid programs.

A 1984 study[12] prepared for HHS also analyzed the determinants of Medicaid spending, using a public expenditure model. This study also identified other important determinants of Medicaid spending: ability to pay, federal cost-sharing through the matching formula, and attitudes about health care for the poor. To capture the effect of political preferences, the study explicitly included an index of state political climate, constructed from data on voting records of federal

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[12] The Evolution of State Medicaid Programs (Center for Health Economics Research).

senators and representatives. Holding all other factors constant, states with a more liberal political orientation were found to be more generous to their poverty populations.

There is considerable focus in the literature on the effect of the federal matching rate on reducing interstate Medicaid disparities. The studies we reviewed agree that higher federal matching rates in low-income states have not been sufficient to offset lower ability to pay for Medicaid services. In fact, as currently structured, the matching formula does not result in even approximately equal access to either acute or long-term care services for the poor. Moreover, although poorer states spend more than they would have in the absence of federal cost-sharing, both coverage of the poor and program expenditures in most low-income states are below those of wealthier states. This indicates that the redistributional objectives of the program have not been met.

In our 1983 report,[13] we suggested that the Congress consider changing the matching formula to improve equity in the financing of Medicaid and thereby reduce interstate variations. We found that per capita income, which the current formula uses to calculate the federal subsidy, is not a good proxy for a state's ability to pay. Consequently, poorer states must still make significantly greater tax efforts to offer even the most basic Medicaid services. For instance, Mississippi's tax burden would be four times that of Alaska or Wyoming if all states were to provide comparable levels of services to the poor.

We identified the measure of tax capacity, developed by the Advisory Commission on Intergovernmental Relations, as a better estimate of potential revenue sources than per capita income. We also suggested that the number of people in poverty in a state be explicitly incorporated into the formula to determine the federal matching rate. Finally, we concluded that reducing the minimum federal reimbursement to 40 percent from 50 percent would enhance taxpayer equity in the financing of Medicaid programs.

We and other researchers concluded that, even if ability to pay were equalized across the states, variation in Medicaid expenditures would still be observed owing to differences in taxpayer preferences concerning the Medicaid program. As long as Medicaid is administered at the state level under broad federal guidelines, sociodemographic characteristics, economic conditions, and political attitudes will play an influential role in shaping the programs.

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[13] Changing Medicaid Formula.

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